



West of the Rockies

Speaker's Corner

Unnerving: a patient's view of the debate over prostate cancer

"For in much wisdom is much grief: and he that increaseth knowledge increaseth sorrow." — Ecclesiastes 1:18

I came to that very same conclusion a couple of years ago when I discovered the disagreements among doctors over screening and treatment of prostate cancer.

In retrospect, I'm not sure if I'm better or worse off for having found out that many of the learned heads in the field are having serious disputes. It's unnerving when you stumble across something like that. It's sort of like having the door to the cockpit of your 737 suddenly swing open, and you witness 2 pilots arguing vehemently about the flight plan.

Especially unsettling was the discovery that doctors have big egos and big emotional investments in their own ways of doing things. Sometimes the scientific method winds up in the back seat. This fact was brought home to me when I was evicted from a world-famous university hospital by uniformed security guards because a renowned surgeon took offense during an interview when I questioned whether prostatectomies actually save lives.

Let's start at the beginning. After my 50th birthday I visited my internist for that dreaded "the times they are a-changing" examination. The only discordant note was that the physician detected a little "asymmetry" in my prostate. My prostate wasn't hard. It wasn't swollen. Just a tad lopsided. Before leaving the office, I had in my hand a lab referral slip for a prostate specific antigen (PSA) test. Until that time, I had only associated the acronym "PSA" with the now-defunct airline that once flew cheap, reliable passenger service up and down the West Coast from its home base in San Diego.

Even though my test results came back normal, indicating no sign of cancer, my internist referred me to a specialist, just to be on the safe side.

A week or so later I visited a urological practice on Telegraph Avenue in North Oakland. Another digital rectal examination confirmed

the asymmetry. As for the PSA result, the urologist dismissed it. "You can have a normal PSA and still have cancer." That was the first shock.

He recommended another round of tests. First, a sonogram, to take a Polaroid picture of the prostate for closer examination. And if that were to prove inconclusive, the next test would be a biopsy. The word "biopsy" has a way of focusing the mind. At this point, I could have said no. The thought just never occurred to me. The next thing I knew, I was standing at the counter in a pharmacy, purchasing a brace of Fleeta enemas to prepare me for the next plateau. The testing procedures were, as physicians say with considerable understatement, invasive. The sonogram was inconclusive, and so the urologist performed the biopsy.

It involves insertion of a wire-like cable up the rectum. At the end of the cable is a razor-sharp set of jaws that are cocked open. After the physician guides it into place against the prostate, he trips the release. Bingo! The minutes awaiting the six clicks of the cable release collecting the specimens of my prostate were among the longest I've spent on this earth. No anesthesia was involved. After it was over, the nurse showed me a beaker full of fluid in which 6 raw bits of my tissue floated lazily to the bottom.

When I returned to the urologist's office for the results of the biopsy, I was apprehensive. A fog lifted when he told me the biopsy was negative. As a precaution, however, he urged me to continue with PSA testing every year.

When I walked out of the office, I first felt liberated, but also profoundly confused. My welcome to the promised land of "early screening" had been anything but reassuring.

Shortly afterward, I shared my experiences with the producers of Soundprint, a public radio program with an emphasis on science. I proposed doing a half-hour radio documentary on prostate cancer, based somewhat on my own experience, as an alert to men my age.

When my proposal was accepted, the door opened to several months of intensive research.

In interviewing many of the leading figures in the field and reading up on the literature, I caught a glimpse of the medical world that patients seldom see. It's not the brave face of conviction and confidence that one usually sees in the clinician. Instead, it's a world fraught with controversy, disputes over research results, and questions that won't go away: What about the efficacy of the PSA test? What about the advisability of the increasingly popular radical prostatectomy? What about the studies from Scandinavia apparently showing that surgery was no more effective in saving lives than watchful waiting?

When I raised these questions with a world-renowned specialist in the field, the interview ended after 20 minutes. The sur-

geon picked up his telephone and called security to have me removed from the building. For a fleeting moment, I felt like the character Harrison Ford plays in the movie *The Fugitive* as I crept around the frozen streets, attempting to sneak back into the hospital to finish my interviews.

When I completed the documentary, I had a small sense of satisfaction that I was able to send up a warning to listeners to be wary of the sweeping claims made about prostate cancer treatment. I became keenly aware of any and all media reports on the topic. The ones that gave me the most concern were those that uncritically endorsed PSA testing and prostatectomy as a remedy for prostate cancer.

Only regular readers of the *Wall Street Journal* would be aware of the very large financial implications of this debate. The

PSA test costs around \$50. Multiply that by the millions of men over age 50 who might be persuaded that a yearly PSA is a good idea. There is the possibility that the number of prostatectomies could grow to 100,000 per year, without any scientific proof so far that this kind of surgery prolongs life any better than watchful waiting.

I'm just not sure that I'm better off knowing all these things.

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Mass immunization: did we do more harm than good?

see also p.392

David Heiden

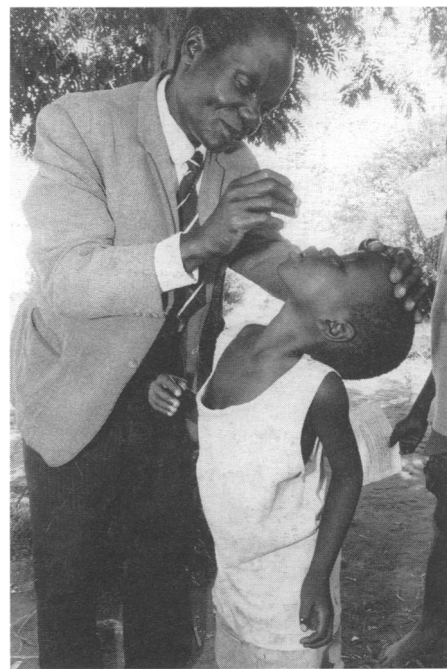
By 1983 the health care system in Uganda was in shambles. It was the immediate aftermath of Idi Amin, and during his 10-year rule, the childhood immunization program had fallen apart. Measles was the leading reported cause of death in the country, and more hospital beds were occupied by patients with measles than for any other disease.

I was there to help restart primary immunization—measles, polio, DPT, and BCG. We knew we were doing something that was needed because almost every day we saw children with withered limbs from polio. In a month we had trained several teams and immunized about 25,000 children. But thinking back on the experience makes me reflect on the complexity of even something as simple as immunization, and the ever-lurking possibility of good intentions leading to more harm than good.

For example, on our third morning we discovered a problem with the "cold chain." The cold packs had been put in the refrigerator instead of the freezer, and they weren't frozen. Without frozen cold packs we couldn't keep measles vaccine viable in the equatorial African heat. At 9 AM we put the packs in the freezer, but by 2 PM they still weren't frozen. It was 4:30 when I finally arrived at the Busia market, the morning immunization site, to

explain that the vaccinations had to be cancelled. The local nurse said that there had been an excellent turnout, about 1,000 children and mothers, plus the village chief, schoolteachers, and clergy, who had been working for weeks to remind and encourage everyone to come. But now, all the people were gone. The crowd had arrived at 8 AM. It had been hot. There was no water and no lunch for the children. The nurse said that the chief had made very nice speeches about immunization all morning, trying to keep the people patient. At noon they sent everyone on foot to the afternoon site 6 miles away. By the time we drove to the afternoon site, everyone was gone except for 6 men sitting in a hut drinking Pombe, the local homemade beer.

Then, in the second week, something worse happened. We drove 2 hours over rutted dirt tracks to reach the appointed village. We unpacked, only to discover that we had left the box of needles behind. The local schoolteachers and village priest who had organized the turnout and had dressed in their best clothes greeted us with nervous eagerness and pride. They had done wonderfully: there were 700 children crowded into the village center. Again, many of the mothers had come 5 or 10 miles on foot.



A teacher administering oral polio vaccine

But we had only two needles. We argued about what to do but finally went ahead, reusing the same 2 disposable needles on 700 children. We didn't know that by 1983 HIV infection had taken hold in Uganda. I can't help wondering if we contributed to the epidemic by our work that day.

—David Heiden, ophthalmologist, San Francisco